



APPLICATION FOR SERVICE
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES/HCBS
SFN 1047 (11-2006)

Date

Agency

Name (Please Print)

I apply for services to assist me with:

FOR YOUR INFORMATION (Please read before signing below)

The agency provides a variety of services based upon your specific needs. Eligibility for services and the fees for our services are individually determined. Some services are without fee. When fees are involved, other sources of funding, such as insurance, will be explored and utilized.

We respect your right to receive prompt, professional service, to be involved in setting the care plan and service goals, and to have records about you kept confidential. The agency will not release any personal information about you (either verbal or written) without your permission except to do so by law or regulation or in the administration of the program. Within the agency, information about you will be shared only with staff who are involved in the administration or provision of services which you receive.

You cannot be discriminated against in any manner related to the receipt of any service, financial aid, or other benefit under the agency or any programs administered by the agency on the grounds of race, color, national origin, sex, or nature of handicap.

In the event you feel dissatisfied with any service provided to you, you are encouraged to call this to the attention of the person providing services to you. If still dissatisfied, you may have a review by the director of the office providing services. In the event the office has not resolved the issue to your satisfaction, you are entitled to an administrative hearing by notifying the Executive Director, Department of Human Services, 600 East Boulevard, Bismarck, ND, in writing, of your dissatisfaction and request for hearing.

Applicant's Signature (or Legal Representative)

Date

Applicant's Signature (or Legal Representative)

Date